COMMONWEALTH OF VIRGINIA
VIRGINIA DEPARTMENT OF HEALTH
STATE CORPORATION COMMISSION - BUREAU OF INSURANCE

ANNUAL COMPLAINT REPORT

Filed pursuant to Sections 32.1-137.6 C and 38.2-5804 of the Code of Virginia

***GENERAL INSTRUCTIONS*:** Each managed care health insurance plan (MCHIP) licensee is required to complete this form annually regarding its complaint system and the processing of its complaints. The form is to be filed with both the Virginia Department of Health and the State Corporation Commission by March 31st of each year. Information reported on this form shall be specific to Virginia covered persons in fully insured plans. If the licensee has multiple MCHIPs, complaints may be consolidated.

Please return this form to the Virginia Department of Health, Office of Licensure and Certification, as a .pdf document e-mail attachment, sent to the following e-mail address: MCHIP@vdh.virginia.gov. Call (804) 367-2104 with questions. Please ask for the MCHIP unit. Send a paper copy of the completed form to the Office of the Managed Care Ombudsman, State Corporation Commission, Bureau of Insurance, P.O. Box 1157, Richmond, Virginia 23218. Call (804) 371-9032 or toll free (877) 310-6560 with questions.

Part I: Identification

Reporting Period: January 1, _____ through December 31, _____.

Name and address of Managed Care Health Insurance Plan Licensee (health carrier):

_____

NAIC Number: _____

Number of Covered Persons in Virginia in fully insured plans_____

Contact Person/Title: _____ Phone Number: ( ) _____
(Please Print)

Email Address: _____

I certify that, to the best of my knowledge, this information is true and accurate.

Signature: _____ Date: _____

Part II: Description of Procedures of Complaint System

Please attach a separate statement identified as Part II that describes the procedures used by the MCHIP licensee to process complaints.

Part III: Direct Services

Complete each category for complaints that involve services directly provided by the MCHIP licensee rather than those services that are provided through a delegated entity. ***If complaints are specific to a leased provider panel, please provide those numbers in Part IV.***

When completing Parts III-VI refer to the definition and to the MCHIP quality of care complaint categories specified in **Attachment A.**

A. Number of Complaints in *All Categories Involving Quality of Care*

Number of …	Pending	Closed	Total
Complaints involving access to health care services			
Complaints involving utilization management			
Complaints involving practitioners and providers			
Complaints involving service delivery			
Other (explain):			
			Grand Total

B. Breakdown of Quality of Care Complaints by Source

1. Total number of complaints in all categories above, (Section A), made by **covered persons**: _____
2. Total number of complaints in all categories above, (Section A), made by **providers**: _____
3. Total number of complaints in all categories above, (Section A), made by **state or federal authorities**: _____

4. Other (please list other sources of complaints):_____
_____

Please note that the total number of complaints for questions 1-4, Section B, should equal the Grand Total number of complaints reported in Section A.

C. Quality of Care Complaint Resolution Timeperiods

1. State the average number of business days to acknowledge a complaint: _____

2. State the average number of business days to close a complaint from date of receipt to closure: _____

3. State the number of complaints that took longer than 60 days to acknowledge, investigate and close: _____

D. Disposition of Quality of Care Complaints

1. Of the total number of complaints shown as closed in Part III. A, specify the disposition of the complaints as follows:

   a. Number of complaints resolved to complainant's satisfaction: _____

   b. Number of complaints where no action was warranted in response to complainant's request: _____

   c. Other types of disposition:_____

2. Have any issues resulting from complaints filed with the MCHIP licensee resulted in quality improvements to the MCHIP's quality improvement plan, systems, processes, or procedures? yes ☐ no ☐ If yes, please give example(s). You may wish to consult with the quality improvement program manager when responding to this question.
   _____
   _____
   _____
   _____
   _____
   _____
   _____

Part IV: Delegated Services Complaints

Delegated services are those health services provided by the MCHIP licensee through a vendor or contract. Contracts could be for leased panels of providers (medical/dental/vision) as well as contracts for entire services (mental health, pharmacy, others). Please complete Table A for complaints regarding delegated services.

Part IV. Table A – Complaints Filed Regarding Delegated Services

Type of Service	Complaints Involving Access to Services			Complaints Involving UR/UM			Complaints Involving Practitioners and Providers		
NAME	Pending	Closed	Total	Pending	Closed	Total	Pending	Closed	Total

Type of Service	Complaints Involving Service Delivery			Other (explain)		
NAME	Pending	Closed	Total	Pending	Closed	Total

See Appendix A for a description of the types of complaints that come within each category.

V: Malpractice Claims

State the total number, total dollar amount and disposition of malpractice claims adjudicated during the year with respect to any of the managed care health insurance plans' health care providers.

Type of Provider	Number	Amount	Disposition

VI: Appeals

Total Number of Quality of Care Appeals

Number of Quality Care Appeals	Total
# Appeals of Non-Adverse Decisions	
# Reconsiderations of Adverse Decisions – Upheld	
# Reconsiderations of Adverse Decisions – Overturned	
# Final Appeals – Upheld	
# Final Appeals – Overturned	

VII: Bureau of Insurance Complaints

Total Number of All Complaints (Excluding Quality of Care)

The State Corporation Commission's Bureau of Insurance will use information in this section. Report all written complaints, **other than quality of care complaints**, received from enrollees, subscribers, members, or from or through the Bureau of Insurance. Direct any questions concerning this section to the Office of the Managed Care Ombudsman, (804) 371-9032 or toll free (877) 310-6560.

Using the three (3) categories provided, complete the chart by reporting the number of complaints and other information as requested.

Major types/cause(s) of all complaints (except quality of care complaints):

1 . Complaints involving or caused by administrative or service issues**.**

Examples include but are not limited to: Enrollee did not receive plan documents, i.e. evidence of coverage, enrollment information, or insurance card. Enrollee did not understand available benefits. Enrollee claimed plan staff members were not responsive to request for assistance, or phone calls or letters were not answered. Marketing or other plan material was not clear. Problems, to include complaints and appeals, were not responded to within required time frames, or were not adequately answered.

2. Complaints involving or caused by billing or claim issues.

Examples include but are not limited to: Claim was not paid, only partially paid, or not paid on a timely basis. Claim was processed incorrectly, or an incorrect copayment or deductible was assessed. Claim was denied because of pre-existing condition. Enrollee held responsible contrary to "hold harmless" contractual agreement between the health plan and provider.

3. Complaints involving or caused by other types of issues not listed above (excluding complaints regarding quality of care of care).

   If this number is more than 25% of **all** complaints, briefly summarize the leading causes of the complaints.

	#1 Admin/Service	**#2 Billing/Claim**	**#3 Other**	**Total**
# of Complaints Received				
# of Complaints closed that resulted in some form of corrective action				
# of Complaints that did not result in some form of corrective action				
# of Complaints open or pending as of the end of the reporting period				
Average # of business days it took to resolve and close a complaint				

TOTAL _____

Total # of Quality of Care Complaints reported in Part III A and Part IV A _____

GRAND TOTAL _____

"Complaint" means a written communication from a covered person primarily expressing a grievance. A complaint may pertain to the availability, delivery, or quality of health care services including adverse decisions, claims payments, the handling or reimbursement for such services or any other matter pertaining to the covered person's contractual relationship with the MCHIP licensee.

MCHIP Complaint Categories Under Quality of Care

I . Quality of Care

A. Access to Health Care Services

1. Geographic access limitations to providers and practitioners
2. Availability of Primary Care Providers/Specialists/ Behavioral and Mental Health Providers
3. Primary Care Provider after-hour access
4. Access to urgent care and emergency care
5. Out of network access
6. Availability and timeliness of provider appointments and provision of services
7. Availability of outpatient services with the network (to include home health agencies, hospice, labs, physical therapy, and radiation therapy)
8. Enrollee provisions to allow transfers to another Primary Care Provider
9. Patient abandonment by Primary Care Provider
10. Pharmaceuticals (based upon patient's condition, the use of generic drugs versus brand name drugs)
11. Access to preventative care (immunizations, prenatal exams, sexually transmitted diseases, alcohol, cancer screening, coronary, smoking)

B. Utilization Management

1. Denial of medically appropriate services covered within the enrollee contract
2. Limitations on hospital length of stays for stays covered within the enrollee contract
3. Timeliness of pre authorization reviews based on urgency
4. Inappropriate setting for care, i.e. procedure done in an outpatient setting that should be performed in an inpatient setting
5. Criteria for experimental care
6. Unnecessary tests or lack of appropriate diagnostic tests
7. Denial of specialist referrals allowed within the contract
8. Denial of emergency room care allowed within the contract
9. Failure to adequately document and make available to the members reasons for denial
10. Unexplained death
11. Denial of care for serious injuries or illnesses, the natural history of which, if untreated are likely to result in death or to progress to a more severe form
12. Organ transplant criteria questioned

C. Practitioners/Providers

1. Appropriateness of diagnosis and/or care
2. Appropriateness of credentials to treat
3. Failure to observe professional standards of care, state and/or federal regulations governing health care quality
4. Unsanitary physical environment
5. Failure to observe sterile techniques or universal precautions
6. Medical records - failure to keep accurate and legible records, to keep them confidential and to allow patient access
7. Failure to coordinate care (example - appropriate discharge planning)

D. Service

1 . Inadequate, incomplete, or untimely response to quality of care concerns by MCHIP staff
2. Conflict of application of MCHIP quality of care policies and procedures with evidence of coverage or policy
3. Breach of confidentiality
4. Lack of access/explanation of to MCHIP complaint and grievance procedures
5. Incomplete or absent MCHIP enrollee notification